COVERSHEET

Minister	Hon Erica Stanford	**Portfolio**	Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions
Title of briefing	High-level summary of findings in the Royal Commission's final report	**Date to be published**	30 September 2025

Withholding grounds

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- section 9(2)(a) to protect the privacy of natural persons

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Crown Response to the Abuse in Care Inquiry

Briefing

High-level summary of findings in the Royal Commission's final report			
Date:	29 July 2024	**Security level:**	
Priority:	High	**Report number:**	CRACI 24/035

Information for Minister	
Hon Erica Stanford **Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions**	This paper provides a high-level summary of the findings (Appendix One) in the Royal Commission of Inquiry into Historical Abuse in the Care of the State and Faith-based Institutions (the Royal Commission): *"Whanaketia – Through Pain and Trauma, From Darkness to Light"* (Whanaketia). The paper also provides early thinking on the approach to responding to the findings. Officials will discuss this with you in your meeting on 31 July 2024.

Contact for discussion			
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Agencies consulted
N/A

Minister's office to complete

☐ Noted ☐ Seen ☐ See Minister's notes ☐ Needs change ☐ Overtaken by events ☐ Declined ☐ Referred to (specify) _____	**Comments**

Briefing

High-level summary of findings in the Royal Commission's final report

For: Hon Erica Stanford, Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions

Date: 29 July 2024 **Security level:**

Priority: High **Report number:** CRACI 24/035

Purpose

1. This paper provides you with a high-level summary of the findings of the Royal Commission of Inquiry into Historical Abuse in the Care of the State and Faith-based Institutions (the Royal Commission). Most of these are in its Final Report "*Whanaketia – Through Pain and Trauma, From Darkness to Light*". It also provides early thinking on the approach to responding to the findings.

2. Officials will discuss this with you in your meeting on 31 July 2024.

Recommendations

3. It is recommended that you:

   a. **note** that there are approximately 230 findings in the summary of the Royal Commission's Final Report as well as roughly 300-400 findings in the seven case studies produced by the Royal Commission;

   b. **note** that a high-level summary of the findings is attached as Appendix One;

   c. **note** that the Royal Commission recommended Government and faith-based institutions publish whether they accept each of the Inquiry's findings in whole or in part, and the reasons for any disagreement;

   d. **provide feedback** on an overall approach which responds to the findings of Whanaketia in broad terms, and in the context of its recommendations, rather than an analysis and response to each individual finding, while retaining the ability to provide specific responses to individual findings as required;

e. **note,** following your feedback, officials will finalise advice on an approach to responding to the findings for Cabinet decisions in September.

Isaac Carlson
Director, Crown Response Unit
Crown Response to the Abuse in Care Inquiry

29 / 07 / 2024

Hon Erica Stanford
Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions

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A high-level overview of the Royal Commission's findings is provided in Appendix One

1. The Royal Commission made approximately 230 findings in the summary of Whanaketia, noting, however, that it is not entirely clear, what constitutes a single finding compared to a group of findings. There are a further 300 – 400 findings in the seven case studies. This is significantly more than the Royal Commission's 138 recommendations. A summary of the findings is attached in Appendix One.

Early thinking is the Crown should respond to the findings in broad terms rather than individually

2. In terms of its findings, the Royal Commission has recommended that:

   "the government and faith-based institutions should publish their responses to this report and the Inquiry's interim reports on **whether they accept each of the Inquiry's findings in whole or in part, and the reasons for any disagreement.** The responses should be published within two months of this report being tabled in the House of Representatives." (Recommendation 130).

3. Given the over 600 findings in the report, a line-by-line analysis and decisions on a response as recommended by the Royal Commission, would be very time consuming. In addition, the Crown no longer has access to all the information on which the Royal Commission based its findings, which would make a thorough analysis of their accuracy very difficult.

4. We are seeking your feedback on an alternative approach which would instead entail us responding to the findings in broad terms. This would involve broadly accepting the findings – and accepting all survivor evidence - but using them as context for how we approach taking action to respond to the recommendations, rather than undertaking a line-by-line analysis and decision on whether we agree with each finding or not. While this would be our overall approach, there may be some areas where we may need to take a specific position e.g., in relation to Treaty breach findings.

5. This would be consistent with the approach the Crown has taken to the hearings, which has been not to contest any of the facts but to focus on hearing survivors' experiences and addressing the issues raised. It would also support us to prioritise resource on responding to the recommendations rather than analysis and decisions around whether we accept each of the hundreds of findings.

6. Clear communications would be needed about why this approach to the findings was taken.

Alternative options for responding to findings

7. Alternative options for responding to recommendation 130 could be to carry out a detailed assessment of either some of the findings or all of them. This would demonstrate greater diligence and 'full compliance' with the recommendation. However, it would take significant time and resource away from focusing on the recommendations risking a lack of progress in the Crown response. A detailed assessment may also look defensive and open the Crown to a perception of not believing survivors.

Next steps

4. Subject to your feedback on early thinking, officials will finalise advice on this for testing with Ministers at the next Ministers' meeting and for confirmation at Cabinet in September 2024.

Appendix One: Summary report – Findings of *Whanaketia* (final report of the Abuse in Care Royal Commission)

26 July 2024

The full set of findings from the Royal Commission's Inquiry into abuse in care are set out in four volumes ("parts") of its 16-volume final report, as well as in its five new case studies, two previous case studies (on Lake Alice Hospital and Marylands school/ Hebron Trust) and the previous interim report on redress.

The findings from the main report are drawn together in the final report's Preliminaries volume, which includes a 27-page summary of the key findings.

This document draws on the Preliminaries volume summary, in four sections:

Circumstances that led to people being placed into care

Key findings - summary

- People were more likely to be placed into State and faith-based care if they experienced poverty, family crisis or violence, parental abuse and neglect, or were Deaf, disabled or mentally distressed (particularly if there was lack of support for the household from others).
- Decision makers believed, usually genuinely but often without foundation, that out-of-whānau care would lead to better life outcomes.
- Parents were often convinced that care placements outside the home or mainstream education would be better for their children.
- Decision-makers included social workers, police, judges, health professionals and needs assessors who generally had little involvement or connection with affected communities.
- The State used formal powers and compulsory and institutional care options in a discriminatory way, more often against Māori.
- Many survivors experienced multiple placements, often due to perceived delinquency or lack of support.

- People in care did not always understand why they were being moved, or to where.
- The State often failed to assess, or inadequately assessed, people's trauma and support needs in care.

Māori and Pacific

- Māori were more likely to be placed in State care, due to colonisation, urbanisation, breakdown of social structures and racism.
- Tamariki and rangatahi Māori made up the majority in social welfare care and were over-represented in other care settings. They were more likely to be sent to harsher institutions such as borstals.
- The State almost always failed to recognise Māori or Pacific world views when removing or placing Māori and Pacific.
- The State did not typically consider in-home whānau, hāpu, iwi or community care placements.
- Between the 1950s and 1980s, Māori and Pacific peoples experienced heightened surveillance and targeting by Police and other State agencies for running away, staying out or behaving in ways perceived as promiscuous.

Deaf, disabled and mentally distressed

- Deaf, disabled and mentally distressed people were often denied or restricted from involvement in decisions about their own lives.
- Decision-making was often influenced by ableist or disablist attitudes, which led to segregation and social exclusion.
- Institutional care was over-used. For many, formal State care was the only option provided, often for their entire lives.
- They were often denied involvement in decisions about their own lives.

Unmarried mothers and adoptions

- Between the 1950s and 1970s, many unmarried pregnant girls and women were placed in faith-based homes which often facilitated adoptions. These placements and adoptions were usually the result of family, religious and societal attitudes including racism.
- Adoption practices were discriminatory and ignored Māori practices. From 1950 to the mid-1980s, adoption practices legally separated tamariki and rangatahi Māori from their whakapapa and identity.

Nature and Extent of abuse and neglect in care

Key findings - summary

- Best available estimates indicated that up to 200,000 people were abused in care between 1950 and 2019. Precise figures are impossible due to data inaccuracies and poor records. The total number may be higher than this estimate.
- Forms of abuse and neglect included: entry into care, psychological and emotional, physical, sexual, racial and cultural, spiritual and religious, medical, solitary confinement, financial and forced labour, and educational.
- Sexual, physical and emotional abuse were the most common forms.
- Neglect occurred across all settings and varied according to the setting.
- Racism and ableist and disablist practices were common across all settings.
- In some settings, some people experienced the over-use of seclusion, over-medicalisation, lobotomies, sterilisation, invasive genital examinations and experimental psychiatric treatments without informed consent.
- Abuse and neglect were pervasive in Social Welfare and Deaf, disabled and mental health residences and institutions. The State often used punishment and control rather than care.
- Some survivors endured multiple forms of extensive and extreme abuse, with severe physical pain and/or mental suffering.
- The highest levels of physical abuse were at residential and institutional care in Social Welfare, education and health and disability care settings. The highest levels of physical abuse in those settings were at Wesleydale and Owairaka Boys' homes in Auckland.
- Māori and Pacific endured higher levels of physical abuse. Deaf and disabled survivors suffered higher levels of all forms of abuse than non-disabled survivors.
- Sexual abuse was more prevalent in faith-based settings than in State care. The highest reported levels of sexual abuse were at Dilworth School, Marylands School and at Catholic institutions in general.
- Children and young people in foster care experienced the highest levels of sexual abuse among Social Welfare settings.
- The highest rates of abuse were in the 1970s, followed by the 1960s, then the 1980s.
- Males experienced higher levels of abuse, including sexual abuse, than females. Females were more likely to experience emotional and sexual abuse than other forms.

Case study – Lake Alice Child and Adolescent Unit, near Marton

- Electric shocks and paraldehyde injections were used as punishment, administered to various parts of the body including the head, torso, legs and genitals.
- Solitary confinement was misused.
- People were exposed to unreasonable medical risks.

Case study – Marylands School and Hebron Trust, Christchurch

- Sexual abuse was pervasive. Abuse and neglect was extensive and extreme.
- Some survivors lived in perpetual fear.
- Abuse was used to punish and intimidate.

Case study – Te Whakapakari Youth Programme on Aotea/Great Barrier Island

- Abuse and neglect was extreme.
- There was severe physical violence, isolation on a small island for days at a time, and death threats through mock executions.

Case study – Kimberley Centre (for disabled people), Levin

- Normalised physical abuse, reflected by the "Kimberley cringe", where people would cower to protect their head if approached quickly.
- Poor nutrition, with people not fed for long periods, or feeding tubes used unnecessarily.
- Absence of purposeful activities for 80% of the time.

Case study – Kelston School for the Deaf, Auckland, and Van Asch College, Christchurch

- Regular sexual, physical, verbal and psychological abuse.
- Linguistic abuse and language suppression.
- Punishment for using Sign Language, no support for Deaf culture and identity.

Case study – Hokio Beach and Kohitere Boys' Training Centre, near Levin

- Normalised and pervasive violence, including severe corporal punishment involving weapons.
- Staff condoning peer-on-peer violence through a "kingpin" system.
- Pervasive sexual abuse.
- Misuse of solitary confinement.
- Normalised racism and cultural abuse.
- Punishment with extreme physical training and inhumane tasks.

Impacts of abuse in care

Key findings

- Many survivors have gone on to lead fulfilling lives, and some have worked courageously to improve the future for people in care.

- Some people who were abused in care took their own lives or died because of their experiences.
- There is evidence of unmarked graves for patients who died at some psychiatric hospitals, particularly at Porirua, Tokanui and Sunnyside hospitals.
- Most survivors suffered harm and have not been able to live their lives to their full potential.
- Impacts have included: Difficulty with maintaining intimate and family relationships; damaged physical, mental and emotional health and wellbeing; lack of education and reduced employment opportunities; increased financial insecurity; periods of homelessness and reduced trust in authority.
- For some, their experiences became pathways to addiction, sex work, criminality and prison, gangs, entrapment in institutional care, and struggles with sexuality and gender identity.
- Māori and Pacific survivors also experienced family and cultural disconnection, loss of identity, and resulting loss of confidence.
- More than 30% of children and young people from Social Welfare institutions went on to serve prison sentences.
- Abuse and neglect had inter-generational impacts.
- Often, reintegration was difficult, and sometimes never achieved, for people in care returning home.
- Deaf, disabled and mentally distressed survivors experienced ongoing discrimination which limited their ability to leave care.
- The lack of acknowledgement or apology from those in power creates further trauma for survivors.
- Abuse and neglect, and inter-generational harm, have contributed to social inequities.
- The average lifetime cost to the survivor of the loss of enjoyment of things that New Zealanders consider are normal day-to-day activities is estimated to be approximately $857,000. *[Martin Jenkins report, "Economic Costs of Abuse in Care", prepared for the Royal Commission]*.
- The estimated total loss of enjoyment cost is between $96 billion and $217 billion. Of this, $46.7 billion is borne by taxpayers, and $172 billion by survivors. *[Martin Jenkins report].*

Factors which caused or contributed to abuse in care

Crown breaches of Te Tiriti o Waitangi

The following were breaches of the principle of active protection in Te Tiriti:

- Depriving whānau, hāpu and iwi of tino rangatiratanga over their kāinga
- Failure to address ongoing effects of colonisation, which contributed to Māori being placed in care
- Failure to appropriately address trauma caused by abuse and neglect in care.

Other Te Tiriti breaches: Māori

- Stripping Māori of their cultural identity through structural racism, breaching the guarantee of tino rangatiratanga and principles of kāwanatanga, partnership, active protection and equity.
- Excluding Māori from decision making and developing policies for the care of Māori, breaching the guarantee of tino rangatiratanga and principles of partnership and active protection.
- Failing to provide appropriate redress for abuse and neglect.

Breaches of care standards

- People in care had rights to care standards that should have prevented abuse and neglect during the Inquiry period. But in some settings, especially disability, mental health and education, government failed to set adequate or overarching care standards.
- In Social Welfare settings, social workers and foster parents breached standards set out in relevant manuals.
- Police breached standards set out in their General Instructions by interrogating young people with violence and without another adult present, and by holding them in Police cells.
- Standards were routinely breached, with daily breaches in many institutions and foster care places, due to lack of resourcing, poor training, and confusion about statutory powers and roles.
- Breaches varied in severity. Some breaches were abuse in themselves, others allowed abuse to happen. They included the failure of some social workers to visit State wards in care.
- Breaches of care standards included: Neglect and abuse, wrongful use of seclusion and solitary confinement, frequent use of corporal punishment, frequent breaches of healthcare standards (at times unlawfully), failure of social workers to visit State wards in care, and serious breaches of transitional and law enforcement standards.

People at the centre of abuse and neglect

- Many of the circumstances leading to people being placed in care made them more susceptible to abuse and neglect.

- Abusers misused their positions of power and control. They were often predatory, exploited vulnerability, acted with impunity, concealed their actions, and avoided accountability. Some abusers were peers.
- Many bystanders – staff, volunteers and carers – failed to stop or report abuse.

Institutional factors

- Inadequate, inconsistent and inaccessible care standards.
- Inaccurate identification or assessment of individual care needs were.
- Poor employment practices, including lack of vetting, sometimes knowingly appointing convicted sexual abusers, and poor training and development.
- Variable, absent or poorly implemented complaints processes, including: Barriers to raising complaints, consistent failures to believe people in care who reported abuse and neglect, leaders prioritising reputations over the safety of people in care, consistent failures to report complaints to Police, ineffective oversight and monitoring, failures of accountability that allowed abuse and neglect to continue.

Systemic failures

- There should have been legislation specific to the care system to protect Te Tiriti and human rights, measures to support home care and minimise institutionalised care, and a national care safety framework.
- People in care, and their families and communities, had limited input into State decisions about care.
- Discriminatory legal and policy settings, underpinned by societal attitudes like racism, ableism and disablism, sexism, homophobia and transphobia, children viewed as delinquent, and negative views on poverty.
- The rights of people in care were generally ignored.
- The State lacked diversity and lived experience of care in its leadership.
- People in care were not safeguarded from abuse and neglect, and there was lack of State accountability.
- The State did not take the steps it should have when it saw signs of system failure, such as legislation, support for care at home, steps to minimise institutional care, a care safety framework, best practice training and development, and independent monitoring and oversight.

Societal factors

- Discriminatory social attitudes contributed to survivors entering care and suffering abuse and neglect (as listed in “systemic failures” above).

Findings of fault (against the State)

- ***Social Welfare:*** Ministers and heads of the Child Welfare Division, then the Department of Social Welfare and its successors, were at fault for matters including: Not consistently supporting whānau to prevent people from entering care; often ignoring Māori perspectives and solutions; failing to properly train, support and monitor caregivers; failing to consistently believe or follow up reports of harm.
- ***Health and Mental Health:*** Ministers and Directors-General were at fault for matters including: Implementing institutionalisation from the 1950s to the 1970s leading to abuse and neglect (despite warnings by World Health Organisation and the 1959 Burns Report); ignoring disabled people's perspectives and solutions; inadequate support for families and lack of emphasis on non-institutional care options; overrepresentation in care negatively affecting Māori, Pacific Peoples, Deaf disabled and mentally distressed individuals; inappropriate use of practices like seclusion and restraint.
- ***Education:*** Ministers, Secretaries and Chief Executives were at fault for matters including: Failing to provide education fit for blind, Deaf, disabled children and young people; failing to support NZ Sign Language and Deaf cultural needs; having less oversight of private schools; and failing to keep children safe in some schools and boarding facilities.
- ***NZ Police*:** Successive Police Commissioners of were at fault for: Failing to address disproportionate representation of Māori in criminal justice; negative experiences of Pacific peoples with policing; insufficient policy and procedure to support Deaf, disabled and mentally distressed people; not consistently following policies related to children and young people such as improper questioning of minors; using Police cells to detain children and young people; negative bias against victims of abuse and neglect; and failures to investigate abuse and neglect allegations against people in care.
- ***Governments*** were at fault for matters including: Racism and ableism in legislation, policies and systems; alienation of Māori, Pacific peoples and Deaf peoples from their families, communities and cultures; allowing abuse and neglect of people in care, failure to ensure people in care were safe; inconsistently addressing disclosed abuse and neglect; and gaps in and loss of records.
- ***State or Public Service Commissioners*** were at fault for: Failing to hold chief executives to account for matters including: not addressing the public service role in being responsible for abuse and neglect in care; not appropriately responding to abuse and neglect complaints; not providing holistic redress for survivors; not addressing public servants not following successive codes of conduct; lack of coherent safeguarding of people in care; no framework for ensuring a diverse and inclusive care workforce.

Lessons identified and changes made

- The State made discrete changes to safeguard against abuse and neglect in care during the Inquiry period, generally from the late 1980s.

- The State was slow to learn and act on critical lessons. Well-intentioned changes were made to prevent and respond to abuse and neglect, but these were not always realised.
- Changes to address over-representation of Māori were not made until the late 1980s.
- Changes were inconsistent across care settings, and were generally smaller than the scale of abuse in care.
- Changes were slow and few in Deaf, disabled and mental health.
- There were some efforts to eliminate discriminatory institutional policies and practices.